Mental Health Provider – Mental Status Evaluation

Employee Name_____
Agency _____

Statement of Situation: (includes facts, specific quotes and observable behaviors)

To Provider: As an employer, it is essential that we assure the wellness of this employee and understand the extent and duration of this employee's inability to perform any of the job functions listed below for a full shift and potentially in an overtime status. Please read the job requirements carefully and provide the necessary information to help us in determining the appropriate action to take in this regard. Please be advised that the inability of the employee to perform any or all of the essential functions of their position may result in the employee remaining on medical leave. If any restrictions are identified, an explanation of the extent must be provided.*

Essential Requirements	***Restriction (Yes or No)***	***Explanation for Yes in Column 2****
(ex.) Is not a threat to safety of self or others		

I saw this patient on ___/ ___ / __ and recommended the following:

☐ Patient may return to work with **NO** restrictions on ___ / ___ / ___ or;

☐ Patient may return to work on ___ / ___ / ___ with the restrictions described above.
If restricted, the duration of these restrictions will be
___ Permanent _____ Time limited to ___ / ___ / ___

The Patient may be re-evaluated on ___ /___ /___

☐ Patient is **NOT** released at this time to return to work.
Next evaluation is scheduled for ___ / ___ / ___

Physician's Name (Please Print) _____ Date _____

Physician's Signature_____ Phone _____

(Shaded areas to be completed by agency)